Chapter 5 Recipient Edits 2000-2999 Individual Updates				
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Version 7.4	November 8, 2006	Multiple	2036	Anson Haley
Version 7.4	**November 27, 2006**	**Multiple**	**2503**	**Anson Haley**

Edit: ESC 2503 Recipient Covered by Medicare B (With Attachment)

Note: Edit 2503 revised November 15, 2006.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M, O	02	All except Package C	Detail	Yes	Yes	0

Disposition	M, O
Paper Claim	Suspend
ECS	Deny
ECS w Attach	CCF
Shadow	Pay
POS	Deny
Adjustments	N/A
Special Batch	Suspend

Edit Description

Fail this edit when an outpatient or medical claim (non-crossover) is for Medicare Part B covered services (revenue group 29, see *Appendix* A) for a recipient who has Medicare B coverage on the eligibility file for the claim dates of service, and there is an attachment that must be reviewed to validate it is an appropriate denial from Medicare.

Edit Criteria

If the claim's DOS are within or overlap Medicare coverage period:

Claim from DOS less than or equal to the Medicare B stop date

Claim through DOS greater than or equal to the Medicare B effective date, fail this edit with EOB 2503

Bypass all Medicare edits if one of the following is true for outpatient claims:

If the revenue code on the claims does not belong to revenue group 29, see *Appendix A*

If primary diagnosis code is:
Prenatal care (diagnosis group 5, see *Appendix A*)
Pregnancy (diagnosis group 6, see *Appendix A*)
Preventive pediatric care (diagnosis group 7, see *Appendix A*)

If the procedure code is:
Specific Medicare waive TPL codes (procedure group 83, see *Appendix A*)

If the provider number is:

- State psychiatric hospital**:**

100273120 Evansville Psych. Children's Center
100272090 Evansville State Hospital – LTC
100273500 Evansville State Hospital
100451050 Richmond State (end dated June 1992)
100269790 Richmond State (end dated June 1980)
100273300 Richmond State Hospital & Psych.
100273130 Larue D. Carter Memorial Hospital
100273320 Madison State Hospital
100272180 Madison State Hospital-ICF/MR
100273150 Logansport State Hospital-ICF/MR

- Other provider is:

100269920 HealthWin (end dated January 1996)

If the region code is 11, 21, or 26

Bypass all Medicare edits if one of the following is true for HCFA 1500 claims:

If primary diagnosis code is:
Prenatal care (diagnosis group 5, see *Appendix A*)
Pregnancy (diagnosis group 6, see *Appendix A*)
Preventive pediatric care (diagnosis group 7, see *Appendix A*)
EPSDT6 (diagnosis group 20, see *Appendix A)*

If the provider number is:

- State psychiatric hospital:

100273120 Evansville Psych. Children's Center
100272090 Evansville State Hospital – LTC
100273500 Evansville State Hospital
100451050 Richmond State (end dated June 1992)
100269790 Richmond State (end dated June 1980)
100273300 Richmond State Hospital & Psych.
100273130 Larue D. Carter Memorial Hospital
100273320 Madison State
100272180 Madison State-ICF/MR
100273150 Logansport State Hospital-ICF/MR

- Other provider is:

100269920 HealthWin (end dated January 1996)

If the procedure code is:
Procedure code on the MED B-Non Covered Services table (procedure group 83)

If the provider type is 04 (rehab. facility) and the procedure code does not belong to the rehab procedure group 51 (92506) or therapy speech group 29 (92507, 92508, W4433 or W4434). Note the procedure code belongs to the listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.

If the provider specialty is 339 (psychiatrist) and the procedure code is 90830 (psychological test by physician) procedure group 52 (90803). Note the procedure code belongs to the listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.

If the provider specialty is 116 (ACSW) and the procedure code is 90801, 90820, 90825, 90830, 90831, 90835, 90841, 90842, 90843, 90844, 90845, 90846, 90847, 90849, or 90853 (psychiatric codes). Note the procedure code belongs to the listed procedure group when the procedure code matches and the claims dates of

service fall within the effective and end date of the procedure code within the group.

If the provider type is one of the following:

04 – Rehab facility	15 – Chiropractor
19 – Optician	12 – School
16 – Nurse	22 – Hearing aid dealer
13 – Public health agency	18 – Optometrist
27 – Dentist	

If the provider specialty is:

113 Psychologist

If the provider specialty is 260 (ambulance) or 261 (air ambulance) and the place of service is:

11 – Office	72 – RH Clinic
51 – CMHC	81 – Lab
71 – PH Clinic	99 – Other

If the provider specialty is:

094 – CRNA	095 – Nurse Midwife
140 – Podiatrist	330 – Ophthalmologist

If the place of service is:

31 SNF	32 NH
33 Custodial Care	
34 Hospice	54 ICF/MR

If the modifier is one of the following:
DME rental (RR), DME used (UE), or DME lease/rental (LL) and the procedure code belongs to the DME procedure group 55 (E0144, E0602, E0616, E0779, E0780, E1390, E1900, K0116, Y1453). Note the procedure code belongs to the listed procedure group when the procedure code matches and the claims dates of service fall within the effective and end date of the procedure code within the group.

If the region number is 11, 21, or 26, bypass edit 2503 and fail for edit 2502.

EOB Code

0566 – Your crossover claim has not been submitted on the correct form, verify and resubmit.

2503 – This member is covered by Medicare Part B; therefore, you must first file claims with Medicare.

2506 – The Medicare EOMB indicates the claim was forwarded to another insurance company. You must attach a denial notice from that insurance company, plus the Medicare EOMB for payment.

2507 – The Medicare EOMB remark code indicates this claim was either denied for inappropriate billing, pended for further review, or covered by another insurance company. You must attach final resolution from Medicare or the other insurance company for payment.

2508 – Your service has been denied. The code billed to Medicaid was not the code billed to the primary carrier or insurer.

ARC

22 – Payment adjusted because this care may be covered by another payer per coordination of benefits

Remark

MA92 – Missing/incomplete/invalid primary insurance information.

Method of Correction

For Date of Service 1-1-06

Check the procedure that is billed on the claim. If the procedure code is a J-Code (you need to check the provider file to look at the provider specialty).

Double click on the provider number.

Click on the provider location that is on the claim.

Click on the service location button.

Look at the provider specialty on the provider service window.

If the provider specialty is 240 or 250, deny the claim.

If the provider specialty is NOT 240 or 250 review the attachment.

If it is a valid* denial (EOMB attachment) from Medicare, override the edit.

If it is not a valid denial, deny the claim.

For Dates of Service before 1-1-06

Review the attachment.

If it is a valid *denial (EOMB Attachment) from Medicare, override the edit.

If it is not a valid denial, deny the claim.

It is a Valid denial attachment if it is applicable to the claim (same services, dates of service, etc.) and, the denial reason is due to:

Medicare non-covered service

Medicare benefits exhausted

Recipient ineligible for Medicare Coverage

If it is not a valid denial, fail this edit with EOB 2503

It is a valid denial attachment if it is applicable to the claim (same services, dates of service, and so forth) and the denial reason is due to:

Medicare non-covered service

Medicare benefits exhausted

Recipient ineligible for Medicare coverage

It is NOT a valid denial if the denial reason is the provider will not take Medicare assignment.

It is NOT a Valid denial if the claim and supporting documentation reflect mismatched procedure codes. In receipt of I letter 20010321, from OMPP, it is imperative that claims are paid only if the code billed to Medicaid is the same code that was originally billed to Medicare. The only exception is if a K code is billed to Medicare and subsequently billed to Medicaid as an E code, when Medicaid does not cover the K code.

If claim has a Medicare payment amount and can be processed as a crossover, delete from batch and route to the mailroom.

Method of correction for EOB 2506:

Check for the EOMB

Look on Medicare EOMB for the recipient name, the dates of service, procedure code and billed amount.

Look to see if the EOMB for Medicare does state that it has been forwarded to another insurance company.

If the EOMB states that Medicare forwarded the claim to another carrier, deny the claim.

If there is not a message on the EOMB from Medicare stating that the claim was forwarded, force the claim.

If there is an allowed-amount, co-insurance and/or deductible, deny the claim.

For UB claim, the date of service, type of bill and/or, revenue code and/or description of the procedure, should match up to the date of service, type of bill and/or, revenue code billed on the claim.

> *NOTE: If not sure of the description of the revenue, click on revenue code to see the description. Also, before Denying, bring to lead or supervisor for approval.*

If the type of bill, or description, or revenue code is not on the attachment, deny with 2508.

Blanket Denial:

If the attachment indicates the service provided is a BLANKET DENIAL, and that it is a pre-existing condition, force the claim for payment. If the provider, hand writes the corresponding procedure code on the claim, this is acceptable.

> *NOTE: This is good for one year from the denial letter.*

Court Orders:

If the attachment is a court order, force the claim to pay.

If Medicare denied the claim for one of the following reasons, it should also be denied by Medicaid with EOB 2507.

19	133	MA02	MA86
20	M2	MA03	MA87
21	M15	MA04	MA88
22	M26	MA08	MA89
23	M27	MA18	MA90
24	M60	MA61	MA92
125	MA01	MA85	MA99

On Medicare short forms, if there is not coinsurance, deductible or psycho amount, you need to deny the claim with 0566.

If the Medicare attachment states that the claim has been forwarded to another carrier, deny the claim with EOB 2506.

Process for Medicare HMO Claims:
Review the attachment for one of the following carriers. **The attachment must state, that the payment is based on Medicare's fee schedule. Check for the word Medicare Replacement or Medicare HMO on the attachment. If the attachment is a Medicare HMO policy, Force the claim to pay. If there was a payment, put the payment amount in the TPL field.**

Advantage Health Plus Choice

Advantage Preferred

Arnett HMO

Humana Gold Plus Standard

Humana Gold Plus Enhanced

Humana Insurance Co.

Humana Choice PPO

Humana Gold Choice PFFS

M-Plan Senior Smart Choice

M-Plan Senior Smart Choice High Option

Wellborn Plans Basic

Wellborn Plans Plus Plan

Wellborn Health Plans

United Mine workers

Railroadman's

Unicare Life & health Insurance

Advantage Health Solutions, Inc.

Unicare Security Choice

Anthem Senior Advantage

United Healthcare Insurance

Anthem Medicare Preferred

Anthem Blue Cross and Blue Shield

Security Choice Plus

United Health Care

Sterling Option 1

Today's Option

Secure Horizons Direct